FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016634

Facility Name: CLAYTON RESIDENTIAL HOME, INC.

Address: 2026 N. CLARK STREET (Number) CHICAGO (City) 60614 (Zip Code)

County: COOK

Telephone Number: (773) 549-1840 **Fax #** (773) 549-2036

IDPA ID Number: 36-2607443

Date of Initial License for Current Owners: 1969

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	RICHARD SGARLATA, C.P.A.
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	252	Intermediate (ICF)	252	92,232	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	252	TOTALS	252	92,232	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	86,360	252		86,612	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	86,360	252		86,612	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.91%

D. How many bed-hold days during this year were paid by Public Aid?
2,817 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/28/1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	194,422	25,214	12,435	232,071		232,071		232,071			1
2	Food Purchase		310,817		310,817	(8,491)	302,326	(9)	302,317			2
3	Housekeeping	259,829	45,223		305,052		305,052		305,052			3
4	Laundry		19,488	74,153	93,641		93,641		93,641			4
5	Heat and Other Utilities			138,924	138,924		138,924	1,628	140,552			5
6	Maintenance	126,974		136,177	263,151		263,151	3,036	266,187			6
7	Other (specify):*											7
8	**TOTAL General Services**	581,225	400,742	361,689	1,343,656	(8,491)	1,335,165	4,655	1,339,820			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,015,802	31,702	1,800	1,049,304		1,049,304		1,049,304			10
10a	Therapy	11,143			11,143		11,143		11,143			10a
11	Activities	117,297	20,607	15,160	153,064		153,064		153,064			11
12	Social Services	291,123		44,283	335,406		335,406		335,406			12
13	Nurse Aide Training		67	350	417		417		417			13
14	Program Transportation			7,790	7,790		7,790		7,790			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,435,365	52,376	71,783	1,559,524		1,559,524		1,559,524			16
	C. General Administration											
17	Administrative	520,747		792,530	1,313,277		1,313,277	(792,530)	520,747			17
18	Directors Fees			240,000	240,000		240,000	(60,000)	180,000			18
19	Professional Services			26,435	26,435	(120)	26,315	(5,401)	20,914			19
20	Dues, Fees, Subscriptions & Promotions			47,146	47,146		47,146	(13,763)	33,383			20
21	Clerical & General Office Expenses	322,834	17,682	84,692	425,208		425,208	(66,965)	358,243			21
22	Employee Benefits & Payroll Taxes			453,647	453,647	8,491	462,138	(2,500)	459,638			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,087	10,087		10,087	(7,121)	2,966			24
25	Other Admin. Staff Transportation			135	135		135		135			25
26	Insurance-Prop.Liab.Malpractice			81,709	81,709		81,709	103	81,812			26
27	Other (specify):*							2,347	2,347			27
28	**TOTAL General Administration**	843,581	17,682	1,736,381	2,597,644	8,371	2,606,015	(945,830)	1,660,185			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,860,171	470,800	2,169,853	5,500,824	(120)	5,500,704	(941,175)	4,559,529			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

CLAYTON RESIDENTIAL HOME, INC.
0016634
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	8,491	
2	FOOD		8,491

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	120	
19	PROFESSIONAL FEES		120

To reclass cost of appealing real estate taxes

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. #0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			90,809	90,809		90,809	41,906	132,715			30
31	Amortization of Pre-Op. & Org.			52,965	52,965		52,965		52,965			31
32	Interest			249,973	249,973		249,973	(227,959)	22,014			32
33	Real Estate Taxes			242,822	242,822	120	242,942	5,021	247,963			33
34	Rent-Facility & Grounds			34,000	34,000		34,000	(19,454)	14,546			34
35	Rent-Equipment & Vehicles			26,179	26,179		26,179		26,179			35
36	Other (specify):*											36
37	**TOTAL Ownership**			696,748	696,748	120	696,868	(200,486)	496,382			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			138,348	138,348		138,348		138,348			42
43	Other (specify):*	41,667			41,667		41,667	(41,667)				43
44	**TOTAL Special Cost Centers**	41,667		138,348	180,015		180,015	(41,667)	138,348			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,901,838	470,800	3,004,949	6,377,587		6,377,587	(1,183,328)	5,194,259			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	41,906	30		9
10	Interest and Other Investment Income	(221,617)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(90)	21		18
19	Entertainment	(6,896)	24		19
20	Contributions	(13,409)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,591)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(27,120)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(902,312)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,168,138)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(15,190)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (15,190)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,183,328)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CLAYTON RESIDENTIAL HOME, INC.

ID# 0016634

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 5,509	6	1
2	MISCELLANEOUS INCOME	(6)	21	2
3	RISK MANAGEMENT FEES	(6,000)	19	3
4	TRUST FEES	(150)	21	4
5	RESIDENT CHRISTMAS GIFTS	(2,500)	22	5
6	Y 2001 SEMINAR	(225)	24	6
7	ICLTC - COPE DUES	(395)	20	7
8	NON-ALLOWABLE SALARY	(41,667)	43	8
9	PAINTING AND DECORATING	(4,348)	6	9
10	NON-ALLOWABLE MGMT FEES	(792,530)	17	10
11	NON-ALLOWABLE DIRECTORS FEES	(60,000)	18	11
12				12
13				13
14				14
15				15
16				16
17				17
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82				82
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84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(902,312)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(9)											(9)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				1,628								1,628	5
6	Maintenance	1,161			1,875								3,036	6
7	Other (specify):*													7
8	**TOTAL General Services**	1,152			3,503								4,655	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative	(792,530)											(792,530)	17
18	Directors Fees	(60,000)											(60,000)	18
19	Professional Services	(6,000)		599									(5,401)	19
20	Fees, Subscriptions & Promotions	(13,804)		34	7								(13,763)	20
21	Clerical & General Office Expenses	(65,957)		315	(1,323)								(66,965)	21
22	Employee Benefits & Payroll Taxes	(2,500)											(2,500)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(7,121)											(7,121)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice				103								103	26
27	Other (specify):*				2,347								2,347	27
28	**TOTAL General Administration**	(947,912)		948	1,134								(945,830)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(946,760)		948	4,637								(941,175)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	41,906											41,906	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(221,617)		(6,342)									(227,959)	32
33	Real Estate Taxes				5,021								5,021	33
34	Rent-Facility & Grounds				(19,454)								(19,454)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(179,711)		(6,342)	(14,433)								(200,486)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(41,667)											(41,667)	43
44	**TOTAL Special Cost Centers**	(41,667)											(41,667)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,168,138)		(5,394)	(9,796)								(1,183,328)	45

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	BARTON HEALTHCARE LLC	100.00%	$ 599	$ 599	15
16	V	20	DUES, SUBSCRIPTIONS		BARTON HEALTHCARE LLC		34	34	16
17	V	21	CLERICAL		BARTON HEALTHCARE LLC		315	315	17
18	V	32	INTEREST		BARTON HEALTHCARE LLC		213,993	213,993	18
19	V								19
20	V								20
21	V	32	INTEREST	220,335	BARTON HEALTHCARE LLC			(220,335)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 220,335			$ 214,941	$ * (5,394)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BARTON MANAGEMENT INC.	100.00%	$ 1,628	$ 1,628	15
16	V	6	REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		1,875	1,875	16
17	V	20	DUES, SUBS. & FEES		BARTON MANAGEMENT INC.		7	7	17
18	V	21	CLERICAL AND GENERAL		BARTON MANAGEMENT INC.		(1,323)	(1,323)	18
19	V	26	INSURANCE		BARTON MANAGEMENT INC.		103	103	19
20	V	27	EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		2,347	2,347	20
21	V	33	REAL ESTATE TAXES		BARTON MANAGEMENT INC.		5,021	5,021	21
22	V	34	RENT OFFICE SPACE		BARTON MANAGEMENT INC.		14,546	14,546	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	RENT	34,000	BARTON MANAGEMENT INC.			(34,000)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 34,000			$ 24,204	$ * (9,796)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JOHN SHLOFROCK	STOCKHOLDER	Administrative	5.4286	SEE ATTACHED	5	10.64%	FACILITY	$ 111,853	17-1	1
2	JOHN SHLOFROCK	STOCKHOLDER	Director	5.4286	SEE ATTACHED	5	10.64%	DIR. FEES	30,000	18-3	2
3	JOE MAGIT	STOCKHOLDER	Administrative	28.5714	SEE ATTACHED	10	28.57%	FACILITY	60,000	17-1	3
4	JOE MAGIT	STOCKHOLDER	Director	28.5714	SEE ATTACHED	10	28.57%	DIR. FEES	30,000	18-3	4
5	ELISA SHLOFROCK-ZUSM	STOCKHOLDER	Clerical	5.4286	SEE ATTACHED	6	15.00%	FACILITY	68,859	21-1	5
6	ELISA SHLOFROCK-ZUSM	STOCKHOLDER	Director	5.4286	SEE ATTACHED	6	15.00%	DIR. FEES	30,000	18-3	6
7	JEAN SHLOFROCK	RELATIVE	Clerical	0.00	SEE ATTACHED	8	20.00%	FACILITY	15,615	21-1	7
8	LEON SHLOFROCK	STOCKHOLDER	Administrative	6.2857	SEE ATTACHED	9	18.00%				8
9	DAVID BECKER	STOCKHOLDER	Director	9.5238	NONE	1	2.86%	DIR. FEES	30,000	18-3	9
10											10
11											11
12											12
13								TOTAL	$ 376,327		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BARTON HEALTHCARE, LLC
Street Address: 465 N. CENTRAL AVENUE
City / State / Zip Code: NORTHFIELD, IL 60093
Phone Number: (847) 441-8200
Fax Number: (847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	29	7	$ 3,525	$	5	$ 599	1
2	20	DUES, SUBSCRIPTIONS	NOTE RECEIVABLE	29	7	200		5	34	2
3	21	CLERICAL	NOTE RECEIVABLE	29	7	1,855		5	315	3
4	32	INTEREST	NOTE RECEIVABLE	29	7	1,258,280		5	213,993	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,263,860	$		$ 214,941	25

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BARTON MANAGEMENT INC.
Street Address: 465 CENTRAL AVE.
City / State / Zip Code: NORTHFIELD, IL 60093
Phone Number: (847) 441-8200
Fax Number: (847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	199,800	8	$ 9,569	$	34,000	$ 1,628	1
2	6	REPAIRS AND MAINT.	RENTAL INCOME	199,800	8	11,020		34,000	1,875	2
3	20	DUES, SUBS. & FEES	RENTAL INCOME	199,800	8	40		34,000	7	3
4	21	CLERICAL AND GENERAL	RENTAL INCOME	199,800	8	(7,772)		34,000	(1,323)	4
5	26	INSURANCE	RENTAL INCOME	199,800	8	604		34,000	103	5
6	27	EMP. BEN. GEN. ADMIN	RENTAL INCOME	199,800	8	13,792		34,000	2,347	6
7	33	REAL ESTATE TAXES	RENTAL INCOME	199,800	8	29,507		34,000	5,021	7
8	34	RENT OFFICE SPACE	RENTAL INCOME	199,800	8	85,477		34,000	14,546	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 142,237	$		$ 24,204	25

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BARTON HEALTHCARE	X		MORTGAGE	$20,833.00	1/27/95	$ 5,000,000	$ 3,500,024			$ 213,993	1
2	N/P-STOCK REDEMPTION							567,928			29,638	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$20,833.00		$ 5,000,000	$ 4,067,952			$ 243,631	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	INTEREST INCOME										(221,617)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (221,617)	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 4,067,952			$ 22,014	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	253,560	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	249,544	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,016)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	251,859	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	120	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 359 For 19 93 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	247,963	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	226,308	8
	1996	231,876	9
	1997	241,881	10
	1998	246,175	11
	1999	244,523	12

CALCULATION OF Y2000 ACCRUAL = 244523 X 1.03 = 251859

ALLOCATED FROM BARTON MGMT - 5021.00

REFUND WAS NOT OFFSET BECAUSE 1993 WAS NOT USE TO SET THE RATE; 1993 WAS AFTER THE FREEZE

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,604 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 85,017 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 52,965 4. Dates Incurred: 1999, 2000

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	17,608		$ 19,250	1
2					2
3	TOTALS	17,608		$ 19,250	3

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	252		1967	1967	$ 255,750	$	35	$	$	$ 240,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1969	591,996		20			591,996	9
10	Various			1971	1,150		20			732	10
11	Various			1972	86,256		20			58,370	11
12	Various			1975	15,890		20			14,000	12
13	Various			1978	11,746		20			11,746	13
14	Various			1979	9,036		20			9,036	14
15	Various			1980	45,469		20			44,529	15
16	Various			1981	17,720		20			17,720	16
17	Various			1982	718		20			718	17
18	Various			1983	57,392		20	2,869	2,869	50,380	18
19	Various			1984	48,928	408	20	2,399	1,991	38,822	19
20	Various			1985	100,852	4,255	20	4,086	(169)	85,705	20
21	Various			1986	156,306	7,486	20	8,194	708	121,739	21
22	Various			1987	25,101	797	20	1,137	340	16,853	22
23	Various			1988	16,259	517	20	711	194	11,078	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				408,216	7,104		14,674	7,570	14,858	32
33	PAGE 12C TOTALS				297,253	7,622		14,867	7,245	31,849	33
34	PAGE 12B TOTALS				124,642	3,290		6,285	2,995	19,214	34
35	PAGE 12A TOTALS				1,063,942	25,181		52,523	27,342	382,931	35
36	TOTAL (lines 4 thru 35)				$ 3,334,622	$ 56,660		$ 107,745	$ 51,085	$ 1,762,276	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	23,627	751	20	1,242	491	14,131	9
10	Various			1990	183,167	5,815	20	8,421	2,606	89,446	10
11	Various			1991	53,962	1,713	20	2,700	987	26,088	11
12	Various			1992	158,472	484	20	7,923	7,439	73,261	12
13	Various			1993	79,548	1,875	20	3,977	2,102	29,698	13
14	Various			1994	105,602	2,708	20	5,281	2,573	34,861	14
15	Various			1995	221,995	5,743	20	11,099	5,356	63,168	15
16	LIGHT FIXTURES			1996	2,926	75	20	146	71	718	16
17	WALLPAPER			1996	787	20	20	39	19	192	17
18	FIRE ALARM SYS			1996	76,500	1,962	20	3,825	1,863	18,169	18
19	COVE BASE			1996	1,358	35	20	68	33	334	19
20	PAINTING			1996	4,278	110	20	214	104	1,052	20
21	RUNNER			1996	620	16	20	31	15	150	21
22	FURNACE DAMPER			1996	1,460	37	20	73	36	347	22
23	CABINETS			1996	1,627	42	20	81	39	351	23
24	BATHROOM REFIN.			1996	28,000	718	20	1,400	682	5,950	24
25	LIGHTING			1996	552	14	20	28	14	133	25
26	BATHROOM REFIN.			1996	71,570	1,835	20	3,579	1,744	14,614	26
27	BATHROOM FIXTURES			1996	1,332	34	20	67	33	313	27
28	CORNER GUARDS			1996	1,098	28	20	55	27	270	28
29	TILE			1996	2,070	53	20	104	51	511	29
30	BATHROOM REFIN.			1996	20,800	533	20	1,040	507	4,333	30
31	AIR CLEANER			1996	7,100	182	20	355	173	1,479	31
32	ROOFING			1996	1,435	37	20	72	35	300	32
33	CABINETS			1996	1,230	32	20	62	30	264	33
34	CARPET			1996	4,428	114	20	221	107	1,013	34
35	ELECTRIC CONNECT.			1996	8,398	215	20	420	205	1,785	35
36	TOTAL (lines 4 thru 35)				$ 1,063,942	$ 25,181		$ 52,523	$ 27,342	$ 382,931	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	4-FURNACES			1997	8,471	217	20	424	207	1,307	9
10	REMODEL ACTV.RM.			1997	7,965	204	20	398	194	1,459	10
11	REMODEL BATHROOM			1997	750	19	20	38	19	152	11
12	FLOORING			1997	1,032	26	20	52	26	204	12
13	PARTITIONS			1997	1,505	39	20	75	36	288	13
14	PHONE SYSTEM			1997	1,991	51	20	100	49	375	14
15	COOLER REPAIR			1997	1,037	119	20	104	(15)	381	15
16	FLOOR TILE			1997	832	21	20	42	21	147	16
17	MOVE PHONE SYSTEM			1997	3,977	102	20	199	97	697	17
18	FIRE CODES DOORS			1997	4,297	110	20	215	105	699	18
19	STEEL ROOF STAIRS			1997	4,974	128	20	249	121	809	19
20	DUNHAM PUMP			1997	3,044	78	20	152	74	481	20
21	AIR DAMPER			1997	2,529	65	20	126	61	389	21
22	CARPETING			1997	3,647	94	20	182	88	667	22
23	TILE			1997	687	18	20	34	16	113	23
24	BOILER			1997	34,723	890	20	1,736	846	5,642	24
25	A/C CIRCUITS			1998	2,141	55	20	107	52	268	25
26	FLOOR TILE			1998	615	16	20	31	15	88	26
27	FLOORING			1998	5,679	146	20	284	138	710	27
28	A/C ELECTRICAL			1998	2,344	60	20	117	57	263	28
29	CEILING TILE			1998	747	19	20	37	18	89	29
30	ELECTRICAL			1998	6,775	174	20	339	165	706	30
31	FIRE RATED PANELS			1998	919	24	20	46	22	96	31
32	COVE BASE			1998	1,037	27	20	52	25	117	32
33	WINDOWS			1998	1,442	37	20	72	35	168	33
34	CARPETING			1998	3,304	85	20	165	80	399	34
35	ROOF SYSTEM			1998	18,178	466	20	909	443	2,500	35
36	TOTAL (lines 4 thru 35)				$ 124,642	$ 3,290		$ 6,285	$ 2,995	$ 19,214	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SMOKE DETECTORS			1998	5,765	148	20	288	140	672	9
10	CIRCUIT PANEL			1998	6,800	174	20	340	166	878	10
11	POWER & LIGHTS			1998	88,880	2,279	20	4,444	2,165	13,332	11
12	CONDENSATE PUMP			1998	2,426	62	20	121	59	363	12
13	POWER CABLE			1998	3,840	98	20	192	94	528	13
14	REFINISH TUBS			1998	3,145	81	20	157	76	406	14
15	DOOR CLOSER			1998	1,500	38	20	75	37	194	15
16	CEILING TILE			1998	1,097	28	20	55	27	142	16
17	FIRE CABLE			1998	1,611	41	20	81	40	189	17
18	SPECIAL CONSLT.			1998	1,671	43	20	84	41	182	18
19	COX LTD			1999	1,094	28	20	55	27	105	19
20	RENOVATE			1999	65,650	1,683	20	3,283	1,600	6,292	20
21	SEWER LINE			1999	2,600	67	20	130	63	217	21
22	HEAT TIMER			1999	3,635	93	20	182	89	334	22
23	TUCKPOINT			1999	9,850	253	20	493	240	863	23
24	BATHROOM FIXTURES			1999	1,158	30	20	58	28	97	24
25	ELECTRICAL			1999	11,460	294	20	573	279	907	25
26	A/C TRANSFORMER			1999	958	25	20	48	23	76	26
27	ELECTRIC PANELS			1999	43,850	1,124	20	2,193	1,069	2,741	27
28	FLOOR TILE			1999	1,479	38	20	74	36	136	28
29	WINDOWS			1999	4,555	117	20	228	111	342	29
30	SPECIALTY CONSULTANT			1999	1,173	30	20	59	29	118	30
31	FIRE DAMPER			1999	12,750	327	20	638	311	1,276	31
32	CEILING			1999	2,925	75	20	146	71	219	32
33	CARPETING			1999	8,820	226	20	441	215	662	33
34	PANELS			1999	611	16	20	31	15	47	34
35	PAINT SYSTEM			1999	7,950	204	20	398	194	531	35
36	TOTAL (lines 4 thru 35)				$ 297,253	$ 7,622		$ 14,867	$ 7,245	$ 31,849	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FIRE DAMPER			1999	7,760	199	20	388	189	485	9
10	ROOFTOP A/C			1999	553	14	20	28	14	44	10
11	A/C SWITCHGEAR			1999	4,000	103	20	200	97	233	11
12	RESURFACE CATWALK			1999	960	25	20	48	23	64	12
13	ELEVATOR DOOR DETECT			1999	1,731	44	20	87	43	109	13
14	A/C INSTALLATION			2000	42,000	494	20	1,050	556	1,050	14
15	ELECTRICAL PERMIT			2000	1,610	29	20	61	32	61	15
16	WALL PANELS			2000	1,178	29	20	59	30	59	16
17	ELECTRICAL DRAWINGS			2000	3,000	67	20	138	71	138	17
18	ELEVATOR FIRE SERV			2000	10,581	215	20	441	226	441	18
19	CARPETS			2000	1,011	8	20	17	9	17	19
20	FIRE ALARM SYSTEM			2000	61,312	1,114	20	2,300	1,186	2,300	20
21	RENOVATION			2000	13,360	243	20	501	258	501	21
22	ELECTRIC RENOVATION			2000	111,500	2,025	20	4,181	2,156	4,181	22
23	TILE			2000	611	15	20	31	16	31	23
24	WINDOWS (258)			2000	102,920	1,869	20	3,860	1,991	3,860	24
25	SEWER/WATER LINE			2000	3,082	30	20	64	34	64	25
26	EMERGENCY LIGHTS			2000	3,496	26	20	58	32	58	26
27	A/C UNIT			2000	4,800	108	20	220	112	220	27
28	FIRE DAMPER			2000	4,325	69	20	144	75	144	28
29	TILE			2000	1,800	17	20	38	21	38	29
30	SEWER LINE			2000	12,564	174	20	366	192	366	30
31	DOOR FRAME			2000	1,864	26	20	54	28	54	31
32	MAINT RM RENOVATE			2000	2,900	46	20	97	51	97	32
33	SLIDING GLASS PANELS			2000	2,339	48	20	98	50	98	33
34	CARPETING			2000	6,959	67	20	145	78	145	34
35											35
36	TOTAL (lines 4 thru 35)				$ 408,216	$ 7,104		$ 14,674	$ 7,570	$ 14,858	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 438,232	$ 5,752	$ 19,071	$ 13,319		$ 341,162	37
38	Current Year Purchases	75,289	27,797	4,609	(23,188)		2,747	38
39	Fully Depreciated Assets	284,060	600	1,290	690		284,060	39
40								40
41	TOTALS	$ 797,581	$ 34,149	$ 24,970	$ (9,179)		$ 627,969	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	4,151,453	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	90,809	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	132,715	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	41,906	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	2,390,245	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

CLAYTON RESIDENTIAL HOME, INC.
0016634
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
CLAYTON RESIDENTIAL HOME	436,797	5,752	18,928	13,176	340,660
BARTON MANAGEMENT, INC.	1,435		143	143	502
TOTALS	438,232	5,752	19,071	13,319	341,162
LINE 29: CURRENT YEAR					
CLAYTON RESIDENTIAL HOME	75,289	27,797	4,609	(23,188)	2,747
BARTON MANAGEMENT, INC.					
TOTALS	75,289	27,797	4,609	(23,188)	2,747
LINE 30: FULLY DEPRECIATED					
CLAYTON RESIDENTIAL HOME	284,060	600	1,290	690	284,060
BARTON MANAGEMENT, INC.					
TOTALS	284,060	600	1,290	690	284,060
TOTALS (Should Tie to Totals on Page 13)					
CLAYTON RESIDENTIAL HOME	796,146	34,149	24,827	(9,322)	627,467
BARTON MANAGEMENT, INC.	1,435		143	143	502
TOTALS	797,581	34,149	24,970	(9,179)	627,969

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	ALLOC-BARTON				14,546			5
6								6
7	TOTAL				$ 14,546 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 19,021 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	1999 FORD VAN	$ 595.00	$ 7,158	17
18					18
19					19
20					20
21	TOTAL		$ 595.00	$ 7,158	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 295	$	$ 295
2	Books and Supplies		67		67
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		55		55
9	TOTALS	$	$ 417	$	$ 417
10	SUM OF line 9, col. 1 and 2 (e)	$ 417			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 1,132

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,322,721	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,233,673		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,712		6
7	Other Prepaid Expenses	15,522		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	17,166		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,630,794	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	19,250		13
14	Buildings, at Historical Cost	3,109,760		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	908,134		16
17	Accumulated Depreciation (book methods)	(2,342,044)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	85,017		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	337,240		22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,117,357	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,748,151	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 160,219	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	106,182		29
30	Accrued Salaries Payable	109,468		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,404		31
32	Accrued Real Estate Taxes(Sch.IX-B)	251,859		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	26,593		35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 667,725	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	461,746		39
40	Mortgage Payable	3,500,024		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,961,770	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,629,495	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,118,656	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,748,151	$	48

*(See instructions.)

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. **#** 0016634 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
INTEREST RECEIVABLE	8,901	
DUE FROM OTHERS	7,000	
SECURITY DEPOSIT	1,265	
	17,166	

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax -		
Non Care Property		

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		

OTHER NON CURRENT LIABILITIES:	Amount	Amount

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,491,332	1	
2	Restatements (describe):		2	
3	Schedule attached	(936,688)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,554,644	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,764,012	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(1,200,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 564,012	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,118,656	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	CLAYTON RESIDENTIAL HOME, IN(#	0016634	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,554,644
Adjustments:		
		-
		-
		-
UNREALIZED LOSS ON MARKETABLE SECURITIES		12,560
TREASURY STOCK		924,128
Total adjustments		936,688
Balance - Beginning of Year		2,491,332
Equity(Deficit) from Page 17 Col 1		2,118,656
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		2,118,656

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,911,539	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,911,539	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,132	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	1,779	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 2,911	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	221,617	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 221,617	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	5,532	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,532	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,141,599	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,343,656	31
32	Health Care	1,559,524	32
33	General Administration	2,597,644	33
	B. Capital Expense		
34	Ownership	696,748	34
	C. Ancillary Expense		
35	Special Cost Centers	41,667	35
36	Provider Participation Fee	138,348	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,377,587	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,764,012	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,764,012	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, # 0016634 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	REFUND FROM 1999 EQUIPMENT RENTAL	20
2	VENDING COMMISSIONS	5,147
3	MISC INCOME (ADJUSTED OFF ON PAGE 5)	6
4	1993 REAL ESTATE TAX REFUND	359
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	5,532

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,266	$ 64,389	$ 28.42	1
2	Assistant Director of Nursing	1,520	1,649	32,827	19.91	2
3	Registered Nurses	10,233	11,016	218,700	19.85	3
4	Licensed Practical Nurses	11,989	12,653	204,611	16.17	4
5	Nurse Aides & Orderlies	55,622	60,020	453,047	7.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	521	533	11,143	20.91	8
9	Activity Director					9
10	Activity Assistants	13,790	14,747	117,297	7.95	10
11	Social Service Workers	23,025	25,006	291,123	11.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,589	25,167	194,422	7.73	15
16	Dishwashers					16
17	Maintenance Workers	9,393	10,190	126,974	12.46	17
18	Housekeepers	30,241	33,305	259,829	7.80	18
19	Laundry					19
20	Administrator	2,080	2,200	86,768	39.44	20
21	Assistant Administrator	1,475	1,508	38,500	25.53	21
22	Other Administrative	7,434	7,903	395,479	50.04	22
23	Office Manager					23
24	Clerical	16,544	17,793	322,834	18.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,519	2,727	42,228	15.49	31
32	Other Health Care(specify)					32
33	Other(specify)	801	851	41,667	48.96	33
34	TOTAL (lines 1 - 33)	211,856	229,534	$ 2,901,838 *	$ 12.64	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	286	$ 12,435	1-3	35
36	Medical Director	104	2,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	1,033	36,164	12-3	45
46	Other(specify) ART THERAPY	433	15,160	11-3	46
47	PSYCHO-SOCIAL	232	8,120	12-3	47
48					48
49	TOTAL (lines 35 - 48)	2,184	$ 76,079		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 0		53

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
NON-ALLOWABLE SALARY	801	851	$ 41,667	$ 48.96
	801	851	$ 41,667	$ 48.96

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SEE ATTACHED			$ 520,748
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 520,748

B. Administrative - Other

Description	Amount
BETCARE	$ 792,530
TOTAL (agree to Schedule V, line 17, col. 3)	$ 792,530
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PENSION PERFORMANCE	PENSION	$ 1,523
FR&R	ACCOUNTING	8,375
WEINTRAUB	LEGAL	179
CALLAHAN, FITZPATRICK	LEGAL	120
ALPHA DATA SERVICES	DATA PROCESSING	3,482
ACCUMED	COMPUTER	1,500
CENTRAL PLAZA/THRESHOLD	COMPUTER	2,781
CDS OFFICE TECHNOLOGY	COMPUTER	290
PURCHASE PRO	PURHCASING CONS	1,000
UNEMPLOYMENT TAX CONS	PERSONNEL PLANNERS	1,185
	* RISK MGMT FEES	6,000
* ADJUSTED OUT PAGE 5		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 26,435

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,244
Unemployment Compensation Insurance	23,036
FICA Taxes	202,499
Employee Health Insurance	154,216
Employee Meals	8,491
Illinois Municipal Retirement Fund (IMRF)*	
CHRISTMAS EXPENSE	10,172
EMPLOYEE BENEFITS	3,486
RETIREMENT PLAN CONTRIBUTION	1,797
CHICAGO HEAD TAX	4,696
TOTAL (agree to Schedule V, line 22, col.8)	$ 459,637

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	22,856
Health Care Worker Background Check	389
(Indicate # of checks performed 56)	
DUES, SUBSCRIPTIONS	281
LICENSES, FEES, PERMITS	1,733
DUES, ICLTC	8,083
ALLOC BARTON	41
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,383

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,967
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,967

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING AND DECO	1995	$ 6,040	3	$ 2,013	$ 1,007	$	$	$	$	$	$	$
2	PAINTING AND DECO	1996	3,529	3	1,176	1,176	588						
3	PAINTING AND DECO	1997	4,594	3	766	1,531	1,531	766					
4	PAINTING AND DECO	1998	7,166	3		1,195	2,388	2,388	1,195				
5	PAINTING AND DECO	1999	4,888	3			814	1,630	1,630	814			
6	PAINTING AND DECO	2000	4,348	3				725	1,449	1,449	725		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 30,565		$ 3,955	$ 4,909	$ 5,321	$ 5,509	$ 4,274	$ 2,263	$ 725	$	$

Facility Name & ID Number CLAYTON RESIDENTIAL HOME, INC. # 0016634 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - 8083.00**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **138,348**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **NO**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **8,491** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw